STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155694	B. WIN			08/31/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
				116 BE			
BE12 NU	JRSING HOME			AUBUR	N, IN 46706		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
F0000							
	This vioit was f	or a Recertification and	F00	.00			
			F00				
	State Licensure	e Survey.					
	Curvoy dotoo:	August 27, 29, 20, 20					
	-	August 27, 28, 29, 30,					
	and 31, 2012						
	Facility number	r. 000306					
	Facility number Provider number						
	AIM number: 1	00273860					
	Cum to the emet						
	Survey team:	ON TO					
	Diane Nilson, F						
	Sue Brooker, I						
	Angela Strass,	RN					
	Rick Blain, RN						
	0						
	Census bed typ	oe:					
	SNF/NF: 100						
	NCC: 4						
	Total: 104						
	Census payor t	type:					
	Medicare: 14						
	Medicaid: 58						
	Other: 32						
	Total: 10 <sup>2</sup>	4					
	The Late	alaa madaa ( ) ( )					
		cies reflect state					
	•	n accordance with 410					
	IAC 16.2.						
		0/00/40 1 0					
	-	9/06/12 by Suzanne					
	Williams, RN						ļ
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATUR	<b>I</b>	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID:

AND PLAN OF CORRECTION  155694  NAME OF PROVIDER OR SUPPLIER  BETZ NURSING HOME  (X4) ID  SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  FRUETX TAG  SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility failed to ensure a physician order was followed regarding a medication decrease for 1 resident in a sample of 10 residents who were reviewed for unnecessary medications (Resident #126).  Findings include:  Findings include:  Review of the clinical record for Resident #126, at 12:07 p.m., on 8/29/12 indicated the resident was admitted to the facility on 5/23/12, with diagnoses including, but not limited to, Alzheimer's dementia. A physician order, dated 8/10/12, indicated to add a diagnosis of dementia with behavioral disturbance.  PROVIDERS, ADNS, and unit managers.  STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN 46706  PREPRIX TAG  PROVIDERS RAN OF CORRECTION PREPRIX TAG  PREPRY TAG  PROVIDERS RAN OF CORRECTION PREPRY TAG  PREPRY TAG  PROVIDERS RAN OF CORRECTION PREPRY TAG  PR	STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER  BETZ NURSING HOME  (X3) ID SIMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  FO282 SS=D SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure a physician order was followed regarding a medication decrease for 1 resident in a sample of 10 residents who were reviewed for unnecessary medications (Resident #126).  Findings include:  Review of the clinical record for Resident #126, at 12:07 p.m., on 8/29/12 indicated the resident was admitted to the facility on 5/23/12, with diagnoses including, but not limited to, Alzheimer's dementia. A physician order, dated 8/10/12, indicated to add a diagnosis of dementia with behavioral disturbance.  STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN 46706  (X5)  PREFIX TAG  PREFIX TAG PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG TAG PREFIX TAG TAG PR	AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A BUIL	DING	00	COMPL	ETED
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A physician order, dated 8/13/12, at 2:00 p.m., indicated to discontinue the Risperidone 0.5 milligrams and begin Risperidone 0.25 milligrams at bedtime.  Another physician order, date 8/27/12, indicated Risperidone 0.25  MAR, the white copy of the physician order is placed in the nursing communication book, the yellow copy sent to pharmacy and the pink copy to be placed in the medical record chart.  3. Systems to ensure alleged deficient practice does not recur;		Review of the clinical record for Resident #126, at 12:07 p.m., on 8/29/12 indicated the resident was admitted to the facility on 5/23/12, with diagnoses including, but not limited to, Alzheimer's dementia. A physician order, dated 8/10/12, indicated to add a diagnosis of dementia with behavioral disturbance.  A physician order, dated 8/13/12, at 2:00 p.m., indicated to discontinue the Risperidone 0.5 milligrams and begin Risperidone 0.25 milligrams at bedtime.  Another physician order, date			by the alleged deficient practice. A 100% audit was completed on 8/30/12 & 8/31/12 of all physician orders with re-writes the DNS, ADNS, and unit managers.  When a physician order is written the licensed nurse assigned to the unit will ensure that the physician order is correctly transcribed to the medication administration recommendation administration recommendation order is placed in the physician order is placed in the nursing communication book, yellow copy sent to pharmacy the pink copy to be placed in the medical record chart.  Systems to ensure deficient practice does not recommendation to the control of the process of the placed in the pink copy to be placed in the deficient practice does not recommendation.	ee; ed s by e ord e the and he alleged ur;		
milligrams one by mouth at bedtime, and discontinue Risperidone 0.5  *Licensed nursing personnel will be in-serviced on the system for tracking and transcribing new						be in-serviced on the system f		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	DING	00	COMPL	ETED
		155694	A. BUIL B. WING			08/31/	2012
		L	D. WING	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		116 BE			
RET7 NII	JRSING HOME				RN, IN 46706		
	T				, <del></del>		T
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
	milligrams.				physician orders by the DNS	or	
					designee by 9/21/12		
	The Medicatio	n Administration			<ul> <li>Unit managers will educate newly hired licensed personne</li> </ul>		
	Record (MAR)	for August 2012,			during orientation on the syste		
	, ,	Risperidone 0.5			for tracking and transcribing r		
		y at bedtime was			physician orders.		
	discontinued of	•			Monday- Friday daily the u	nit	
		0.25 milligrams at			manager will audit all new		
	-	_			physician orders in the nursin	-	
	Decime was s	started on 8/28/12.			communication book to ensur		
					orders are correctly transcribe	ea to	
		iterviewed at 12:50			the MAR. A Medication Error Form w	ill	
	-	12, and indicated the			be completed with all orders t		
	Nurse Practition	oner had visited on			have not been transcribed.		
	8/13/12, and v	vrote an order to			·Nursing admin will monitor		
		Risperidone from 0.5			transcription audits and		
		0.25 milligrams at			Medication Error Forms		
	_	indicated this was not			completed by unit manager d	aily	
		sing, and the order was			Monday-Friday and conduct		
	not transcribed	•			re-education and/or disciplina	ry	
		I to the MAIN.			action as needed. 4. Monitoring to ensure	مالمصطالد	
	The Discrete	f Niversia a Compiler -			deficient practice does not rec		
		f Nursing Services			·DNS and/or designee will	, , , , , , , , , , , , , , , , , , ,	
	-	vent report at 2:35 p.m.			complete the Medication Erro	rs	
		nich was dated 8/27/12,			CQI to ensure physician orde		
	at 1:00 p.m., r	egarding a medication			are correctly transcribed. CQI		
	error for the R	isperidone. The			form will be completed weekly		
		atment error report			4, monthly x 3, and then quar	•	
		/13/12, the Risperidone			thereafter to monitor. Findings		
		d to 0.25 milligrams, but			be brought to the CQI commit monthly then quarterly with	ilee	
		erred to the MAR.			tracking and trending discuss	ed	
	was not trainst	oned to the MAIX.			If CQI reveals below the 90%		
	   LDN #4	ad a copy of the Nives			threshold an action plan will b		
	-	ed a copy of the Nurse			implemented.		
		progress note, at 3:00			5. Date of Completion: 09/21/	12	
	l •	2, which was dated					
	8/13/12, and in	ndicated an attempt					
	would be mad	e to decrease the					

PRINTED: 10/05/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	00	(X3) DATE SURVEY  COMPLETED			
MIDILAN	155694	A. BUILDING		08/31/2012			
	100004	B. WING	I D D D D G G G G G G G G G G G G G G G				
NAME OF I	PROVIDER OR SUPPLIER	116 BE	ADDRESS, CITY, STATE, ZIP CODE	3			
BFT7 NI	JRSING HOME	AUBURN, IN 46706					
			I	(7/5)			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	TION (X5) D BE COMPLETION			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE DATE			
	Risperidone.						
	LPN #1 indicated LPN #2 was						
	working on the memory care unit on						
	8/27/12, and discovered the						
	Risperidone order from 8/13/12 had						
	not been transcribed to the MAR, so						
	informed the Nurse Practitioner, who						
	then re-ordered the Risperidone to be						
	decreased to 0.25 milligrams at						
	bedtime.						
	3.1-35(g)(2)						
	10.00						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MZ9Q11

Facility ID: 000306

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155694	(X2) MI A. BUII B. WIN	LDING G	ONSTRUCTION  OO	(X3) DATE COMPL 08/31/	ETED
	ROVIDER OR SUPPLIER			116 BE	ADDRESS, CITY, STATE, ZIP CODE TZ RD RN, IN 46706		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0309 SS=G	must provide the services to attain practicable physic psychosocial well the comprehensive care.  Based on recordinterview, the fanotify the physic change in condiscontinue a cafter the reside failed to docum and emergency before being trained to after the reside failed to docum and emergency before being trained to the discharged on a serviewed or p.m., and indicated admitted to the discharged on included respirated obesity, hyperto (Percutaneous Gastrostomy) to	st receive and the facility necessary care and or maintain the highest cal, mental, and being, in accordance with re assessment and plan of acility failed to promptly cian after an acute lition, failed to ontinuous tube feeding in thad vomited, and itent an assessment remainder the resident expired, ent reviewed for (Resident #149).  e:  ord for Resident #149 on 8/28/12, at 3:27 ated the resident was facility on 5/17/12 and 5/21/12. Diagnoses atory insufficiency, betes mellitus type 2, ension, and PEG Endoscopic ube placement. The indicated the resident	F03	09	F309 Provide Care/Service Highest Well Being Residents affected by the alleged deficient practice;  One resident (#149) was for to have been affected by the alleged deficiency. This reside is deceased.  1. All residents with acute change in condition are at risk be affected by the alleged deficient practice; The Physician will be notified with acute change of condition the physician does not return to call within a timely manner, the Medical Director will be called the DNS will be notified. If the resident is experiencing a life threatening change, first aid measures are to be initiated as needed and 911 will be contact immediately. The DNS will be notified as soon as the resider needs are met. Licensed personnel are to to notes of any assessment information obtained, time the physician was notified, and an first aid measures initiated. No	und nt to d . If he e and sted ut's	09/21/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155694	A. BUII B. WIN			08/31/	2012
			b. why		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	R		116 BE			
RET7 NI	JRSING HOME				RN, IN 46706		
	TOING HOWL			AODOIN			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					are to be summarized and		
	Further review	of the closed record, at			documented in the resident's		
	11:09 a.m., on	8/29/12, indicated the			medical record once the resident's needs are met.		
	resident was d	ischarged to the			Resident's with acute chang	ne.	
	hospital on 5/2	_			in condition will then be placed	-	
	respirations ha				Hot Charting and documented		
	respirations na	d ccasca.			every shift x 72 hours.		
	Daview of a Li	stam, and Dhysical				alleged	
		story and Physical,			deficient practice does not rec		
	•	rom the hospital,			·Licensed nursing personnel	will	
	indicated the re	esident was admitted to			be in-serviced on policy and		
	the hospital on	4/6/12 due to			procedure on Resident Chang		
	Ventilator-depe	endent respiratory			Condition: Acute Medical Change	•	
	failure, status r	oost tracheostomy,			and Life Threatening Change the DNS and/or designee by	БУ	
	· ·	tus post percutaneous			9/21/12.		
	endoscopic ga	•			·Staff Development Coordinate	ator	
		us, and right upper			will educate newly hired licens		
					personnel during orientation o		
	Гехпеницу аеер Г	vein thrombosis.			Resident Change of Condition	:	
					Acute Medical Change and Lif	e e	
		resident progress			Threatening Change.		
	nursing notes i	ndicated the following:			·All acute medical changes a		
					life threatening changes will be		
	5/20/12 8:58 p.	.m. Resident was alert			reviewed by the DNS or desig to assure appropriate	nee	
	•	mes 3 and cooperative,			interventions were initiated, the	<b>e</b>	
		ow simple tasks and			physician was notified and	•	
		ons appropriately.			responded timely and		
		ube (G-tube) dressing			documentation in the medical		
					record is completed with		
	•	tact and no redness			re-education and/or disciplinar	У	
		g through G-Tube was			action as needed.		
		s than 300 cubic			4. Monitoring to ensure	•	
	`	c) of gastric content			deficient practice does not rec DNS and/or designee will	ur;	
	was noted.				complete the Change of		
	5/21/12 at 12:4	11 a.m. The weekly			Condition CQI to ensure		
		dicated the resident			assessment, notification and		
	_	roughout the night			documentation of Resident		
		ty, and awakened			Change of Condition. CQI form	n	
		ly, and awanched					

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	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155694	B. WIN	G		08/31/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DET7 NII	IDOINO HOME			116 BE			
BE IZ NU	JRSING HOME			AUBUR	RN, IN 46706		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	will be completed weekly x 4, 1	hon	DATE
		pal and tactile stimuli.			monthly. Findings will be brough		
		ated oxygen was given ninute via nasal			to the CQI committee monthly	•	
		ations were even and		with tracking and trending			
	•	distress or shortness of			discussed. If CQI reveals below the 90% threshold an action place.		
	· ·	en was soft and			will be implemented.	an	
	· ·	Glucerna was infusing			·5. Date of Completion:		
	•	tube. The nursing note			09/21/12		
	_	d the resident was					
		stomach upset and					
		medication was given					
	through the G-t	•					
	_	a.m., indicated the					
		king his oxygen tubing					
		mes during the shift,					
		or shortness of breath					
	was noted.						
	5/21/12 at 6:13	a.m., indicated the					
	resident was no	oted to have 2 medium					
	emesis of undig	gested tube feeding,					
	no residual was	s noted, the abdomen					
	was soft and no	ontender, bowel					
	sounds presen	t in all quadrants, and					
		ated he was coughing					
		sis. The resident also					
		athing treatment					
	, ,	d him to cough and get					
		nedication. The note					
	· ·	hysician was notified.					
		o.m., The resident did					
	•	f any nausea or					
	_	nift and the G-tube was					
	·	residual noted when					
	placement was						
	5/21/12 12:20 p	o.m., The G-tube					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155694	B. WIN			08/31/	2012
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8		116 BE			
BETZ NU	JRSING HOME				N, IN 46706		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	around the G-t	changed and the area ube was red with a of brown drainage					
	dated 5/21/12 athe resident's to degrees, pulse minute, respiration	sign documentation, at 1:03 a.m., indicated emperature was 97 was 97 beats per ations were 18 per pressure recorded at e oxygen saturation					
	progress notes p.m. on 5/21/12 indicated the pregarding the resident was notes breath and tacksigns of cyanostaken and the prespirations 20	, blood pressure cygen saturation level					
	was called aga 5/21/12, and a 5/21/12 at 8:25 physician calle send the reside Emergency roo	indicated the physician at 8:15 p.m. on nursing note dated p.m., indicated the d and left orders to ent to the hospital om. The note also esident's family was					

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Event ID: MZ9Q11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION  00	COM	TE SURVEY PLETED	
		155694	B. WING		08/3	31/2012
	PROVIDER OR SUPPLIEF JRSING HOME	3	116	ET ADDRESS, CITY, ST BETZ RD BURN, IN 46706	ʿATE, ZIP CODE	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCE	IVE ACTION SHOULD BE CED TO THE APPROPRIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DE	EFICIENCY)	DATE
	p.m., indicated notified again a to transport the Emergency room.  There was not in the medical	the physician was and agreed for the EMS e resident to the om.				
	p.m., on 8/29/1 worked on East shift of 5/21/12 down both hall Resident #149 nurse gave the medications. So resident was to hoyer lift and reassisted him of 5/21/12 to use to She indicated to communicate the indicated the reand she report She indicated a p.m., on 5/21/1 working on and over to help RI she knew the rehad reported to RN#5. She indicated to the results of the she was the reported to help RI she knew the rehad reported to the she was the she was the reported to the she was the reported to the she was the	he remembered the ansferred using a emembered she had not the evening of the urinal or bedpan.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155694	B. WIN			08/31/2012
NAME OF B	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	KOVIDER OR SUPPLIER			116 BE	TZ RD	
	JRSING HOME				N, IN 46706	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE	DATE
	' '	on the resident				
		as sick. QMA #6				
		vent into the resident's				
		nes that evening				
		sident had turned his				
	_	e time for a bedpan				
	and one time b	ecause of the emesis.				
	LPN #8 was in	terviewed, at 2:06 p.m.,				
	on 8/29/12, and	d indicated on the				
	morning of 5/2	1/12, during shift				
	report, the prev	vious shift reported the				
	resident had vo	omited on the night				
	shift. LPN #8 i	ndicated she went in				
	the resident's r	oom and checked for				
	residual from tl	ne feeding tube and				
		e. She indicated the				
	resident had a	good day, was up in				
		visitors, went to				
		o vomiting, and did not				
	complain of an	ything during her day				
	shift.					
	She indicated	when she left the				
		p.m., on 5/21/12, the				
	resident was fi					
	RN #5 was into	erviewed, on the				
		::42 p.m., on 8/29/12.				
	1	she had worked at the				
	She indicated	mately one year.				
		n 5/21/12 and was told				
		sident had vomited on				
		indicated that evening				
	atter the CNAs	transferred the				

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155694	B. WIN	G		08/31/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DETT	IDOINO HOME			116 BE			
REIZNU	JRSING HOME			AUBUR	N, IN 46706		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DETCIENCT)		DATE
		from his chair, they					
		told her the resident					
	was "turning bl	ue. She did not remember					
		occurred, but she					
		ician, who did not					
		way. She indicated					
		again and was told to					
		ent to the hospital. She					
		tarted working at 2:00					
		2, and the resident					
		time. She indicated					
		is breathing treatment,					
		ne was nauseous, and					
		in bed. She indicated					
		emember if she gave					
		ything through the					
	_	at night, but indicated					
		the feeding tube off					
	_	he indicated the CNA					
		e from the other hall					
		turned off the feeding.					
		when the CNAs called					
		ident's room, he was					
		ndicated at that time					
		IAs to elevate his					
		when she had gone					
		ne resident was in bed					
	and his head w						
		she assessed the					
		ok his vital signs, and					
		physician. She					
		CNAs were in the					
	room when she						
	pnysician. She	e indicated when the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155694	B. WIN		<del></del>	08/31/	2012
			р. W II V		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		116 BE			
BETZ NU	JRSING HOME				N, IN 46706		
(X4) ID	STIMMADVS	TATEMENT OF DEFICIENCIES	1	ID	,		(Y5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	CROSS-REFERENCED TO THE APPROPRIATE		TE	DATE	
		ived, the resident was					
	still breathing.	ived, the resident was					
	Suii breauing.						
	CNA #7 was in	iterviewed, on the					
		l:28 p.m. on 8/29/12.					
		she worked the East					
		and had taken care of					
		1 5/20/12 as well as					
		ndicated the resident					
		, was a 2 person assist,					
		nad a feeding tube and					
		nd not lie down due to					
	this. She indica	ated when she took					
	care of him on	5/20/12, and the					
	resident was fi	ne. She indicated she					
	and another Cl	NA, who no longer					
	worked at the f	facility, worked together					
	on the East ha	II. She indicated at					
	approximately	2:00 p.m., or so, she					
	remembered s	eeing the resident,					
	when she was	checking rooms and					
		esident didn't look like					
	he was feeling	well. She indicated he					
		ne recliner, and looked					
		red." She indicated					
		her CNA did rounds,					
		e residents, toileting,					
		t up for dinner. She					
		dent #149's call light					
		d 6 p.m., and she					
		er CNA to go into the					
		n with her. She					
		esident had vomited					
		of "stooped over " in the					
		·					
	i chair. She ind	icated he seemed fairly					

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155694	B. WIN	IG		08/31/	2012
NAME OF P	PROVIDER OR SUPPLIER	-		STREET A	ADDRESS, CITY, STATE, ZIP CODE	_	
				116 BE			
BETZ NU	JRSING HOME			AUBUR	N, IN 46706		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	· ·	the CNAs he didn't feel					
	•	ted to go to bed as he					
	was afraid he v	vould fall out of the					
	chair. CNA #7	indicated they cleaned					
	the resident up	and put him to bed.					
	She indicated h	ne seemed a little					
	better for 20 mi	inutes or so, and they					
	were in the roo	m with him a large					
	"chunk " of time	e that night. She					
	indicated after	20 minutes, he					
	vomited again.	She indicated he was					
	vomiting after t	hat, sometimes a little					
	bit, sometimes	g"quite a bit." She					
	indicated arour	nd 7:30 -8 p.m., he					
	"kind of went u	nresponsive." She					
		rst time the resident					
	vomited she to	ld RN #5. She					
	indicated the n	urse came in the room,					
		the resident to see					
	•	ing. She indicated the					
		ying to tell them he					
		uble breathing. He					
	_	ly take off his oxygen					
	•	cated he had also					
	done this prior						
	•	ed she didn't see any					
		ther then RN#5 in the					
		that evening. She					
		5 had hooked up a vital					
		the room and his					
	oxygen was "re						
		ould see the resident's					
	pulse and oxyg						
	monitor.	CH ICVCI OH WIC					
		the nurse had placed					
	Sile indicated	the nurse had placed					

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155694	B. WIN	IG		08/31/	2012
NAME OF P	ROVIDER OR SUPPLIER	_		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				116 BE			
BETZ NU	JRSING HOME			AUBUR	N, IN 46706		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	onitor on him the first					
		d. She indicated the					
		een unresponsive even					
		ulance arrived. She					
		esident turned a "bluish					
	' '	efore the ambulance					
		e was making a					
		lling" noise and it					
		s "aspirating on his					
		n though we had him					
	sitting up." She	e indicated she and the					
	other CNA wer	e checking him often					
	and called the	nurse in quite a few					
	times. She ind	icated the ambulance					
	arrived around	9 p.m. and before this					
	time the reside	nt's oxygen level was					
	running betwee	en 40 and 80, and most					
	of the time bou	nced around the mid					
	50 to low 60's.	She indicated the					
	resident at first	was trying to talk, but					
	as time went or	n, was making hand					
	gestures, movi	ng his head around,					
	and was not ve	rbal. She indicated					
	about 1/2 hour	before the ambulance					
	arrived, they co	ould not get any					
	response out o	f him, and he would					
	•	yes. She indicated she					
		started turning blue					
	around 7:30 -8	_					
	The Director of	Nursing Services					
		N #1, the East hall Unit					
	, ,	interviewed at 10:34					
	_	2. The DNS indicated					
		een employed at the					
	<u> </u>						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155694	B. WIN			08/31/	2012
		_		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	₹		116 BE	TZ RD		
BETZ NU	JRSING HOME				N, IN 46706		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	facility since A	ugust, 2012 and was					
	not employed	at the time of the					
	incident, however, LPN #1 was employed at that time.						
	LPN #1 indicated she was not in the						
		me of the incident, but					
		one call from RN #5 and					
		vening shift supervisor.					
		she was not available					
		called, but then called					
		I was told about the					
		dition. She indicated by					
		eturned their call, the					
		Iready been taken to					
	the hospital.						
		LPN #1 were informed					
	regarding the	concerns about the					
	documentation	and assessment, and					
	indicated they	would investigate to					
	see if they cou	ld find other					
	documentation	1.					
	The Director of	f Nursing Services					
		erviewed, at 2:40 p.m.,					
		d indicated she could					
	· ·	rther documentation in					
	1	ord. She indicated she					
	l -	N #9 who indicated she					
		l#5 on 5/21/12, and					
		the feeding tube					
		NS indicated the					
	corporate nurse had reviewed the						
	entire record o	n 8/29/12, and was not					
	able to find any	y further					
	documentation	1.					
	I						I

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Event ID: MZ9Q11

Facility ID: 000306

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PRINTED: 10/05/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155694		A. BUI	LDING	NSTRUCTION 00	COM	E SURVEY PLETED 31/2012	
	PROVIDER OR SUPPLIEF	<u> </u>	B. WIN	STREET A			
DEIZING	TROING HOME			AUBUR	N, IN 46706		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	on 8/30/12, wi She indicated a Central hall on 5/21/12, and the from East hall evening of 5/20 come to East H Resident #149 thought they can she had worked long time and the indicated where resident's room was not doing color was very his feeding tube turned it off as the resident hat indicated RN # resident's room after she left the told RN #5 that physician and the hospital. So never seen the but his breathing indicated she to and didn't remaindicated it was indicated she to cyanosis, but the "really pale."	She indicated she ame to her because d on East Hall for a shey knew her. She is she went into the in, he was in bed, and well. She indicated his pale. She indicated e was running and she the CNAs had told her indicated to call the send the resident out to the indicated she had a resident before this, and was not good. She is oxygen level the indicated she had her indica					

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Event ID: MZ9Q11

Facility ID: 000306

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
		155694	B. WIN			08/31/	2012
		<u> </u>	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	3		116 BE			
BET7 NI I	IRSING HOME				N, IN 46706		
				<u> </u>	14, 114 407 00		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	-	e was not responsive.					
	She indicated she listened to his chest and indicated, "I thought he had probably aspirated."						
	The DNS was	interviewed at 9:29					
		12, and indicated the					
	-	completed related to					
	-	Resident #149 was					
		ng 911 if the physician					
	could not be reached.						
		inservice, dated					
	•	rovided by the DNS, at					
	-	ated, "send full code					
		for resp (respiratory)					
	failure" and "ge	et code status					
	immediately up	oon admission to					
	facility. "						
	_						
	RN #11 was in	terviewed, with the					
		at 9:45 a.m., on					
	-	ndicated she had					
		ening of 5/21/12, and					
		•					
		anager on Central hall.					
		LPN #9 had told her					
		s sending one of the					
		e hospital. RN #11					
		only went to the					
	resident's roon	n for approximately 5					
	minutes prior to	o the ambulance					
	-	id not assist with the					
	_	nly helped with the					
	paper work.	,					
	Papai Work.						
	Review of an E	Emergency Medical					

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Event ID: MZ9Q11

Facility ID: 000306

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PRINTED: 10/05/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	(X3) DATE		
AND PLAN	OF CURRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155694	B. WIN			08/31/	ZU 1Z
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
חרדש גיי	IDOING LIGHT			116 BE			
BEIZNU	JRSING HOME			AUBUR	N, IN 46706		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	) prehospital patient					
	• •	ted 5/21/12, indicated					
		nded to a 911 call					
		sident with difficulty					
	_	en they arrived at the					
		n, the resident was					
		e position in bed in a					
		e resident had oxygen					
	•	ninute via nasal					
		nas a feeding tube					
	_	report indicated,					
		t of vomit in the					
	· .	nd all over the floor					
	next to the bed	and soiled hospital					
	gown and linen	s on the chair next to					
	the patient.						
	Nursing staff re	ports that the patient					
	had began to v	omit at about 1800 this					
	evening and th	at they believe that he					
	had aspirated a	at that time. Nursing					
	staff reports that	at at that point the (sic)					
	moved the pati	ent to the bed.					
	Patients skin w	as purple and with					
	respirations at	4 per minute. Patient					
	still vomiting la	rge amounts from nose					
	and mouth."						
	The resident w	as taken by cot and					
	bagged using o	oxygen. The resident					
	was suctioned	"many times while in					
	the ambulance	" and when placed on					
	the monitor sho	owed asystole , no					
		rations, and the pupils					
		nd non reactive. CPR					
	was started wit	hout improvement or					
	change.	•					
							l .

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Event ID: MZ9Q11

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l í			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155694	B. WIN	IG		08/31/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DET7 NIII	IDOING HOME			116 BE			
	JRSING HOME				N, IN 46706		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG	REGULATORT OR	ESC IDENTIFY THO IN ORMATION)		IAG			DATE
	Review of the r	policy for change in					
		ided by the DNS, at					
	-	31/12, indicated the					
	following:	70 17 12, maioatoa 1110					
	_	of this facility that all					
		ident condition will be					
	_	to the physician and					
		ble party, and that					
		nely, and effective					
	intervention oc	curs. "					
	The Procedure	for life threatening					
	change indicate	ed the licensed nurse					
	would initiate a	ppropriate first aid					
	measures until	emergency response					
	personnel arriv	ed on the scene, the					
	licensed nurse	would inform the					
	attending phys	ician, alternate					
	physician, or M	ledical Director of					
		as soon as possible					
	_	or after the change of					
		red or when the					
		nad been managed,					
		the notification.					
		ng actions, physician					
	· · · · · · · · · · · · · · · · · · ·	esident assessment					
		uld be documented in					
		cord, and the nursing					
	supervisor wou						
	changes of cor	life threatening					
	The "Acute Me						
		cated the following:					
	-	or serious change in a					
	•	lition manifested by a					
	residents conc	mion marinesieu by a					

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Facility ID: 000306

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	OF CORRECTION IDENTIFICATION NUMBER:  155694	A. BUILDING  B. WING	00 	COMPLETED  08/31/2012				
	PROVIDER OR SUPPLIER  JRSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE  116 BETZ RD  AUBURN, IN 46706						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE				
	marked change in physical or mental behavior would be communicated to the physician with a request for physician visit promptly and/or acute care evaluation.  If unable to contact the attending physician or alternate physician in a timely manner, notify the Medical Director for medical intervention.  All nursing actions/interventions would be documented in the medical record as soon as possible after resident needs have been met.  3.1-37(a)							

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Event ID: MZ9Q11

Facility ID: 000306

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155694	B. WING			08/31/	2012
NAME OF T	DROLUDED OF GUREY TO				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	<u>C</u>		116 BE	TZ RD		
	JRSING HOME				N, IN 46706		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
		LSC IDENTIFYING INFORMATION)	+	IAG	DEFICIENCY)		DATE
F0322 SS=G	483.25(g)(2) NG TREATMENT EATING SKILLS Based on the cora resident, the far resident who is fe gastrostomy tube treatment and sepneumonia, diarrimetabolic abnorm nasal-pharyngeal possible, normal Based on recointerview, the far resident in a feeding tube, For the proper treat gastrostomy tube aspiration, resudeteriorating control to the closed recover was reviewed to p.m., and indicadmitted to the discharged on included respir dysphagia, dialobesity, hypert (Percutaneous)	r/SERVICES - RESTORE  Inprehensive assessment of cility must ensure that a ed by a naso-gastric or receives the appropriate rivices to prevent aspiration hea, vomiting, dehydration, nalities, and ulcers and to restore, if eating skills.  Indicate the definition of the eating skills are review and acility failed to ensure sample of 2 with a resident #149, received the three to prevent culting in the resident's condition, transfer to the resident expired.  Ide:  Ord for Resident #149  On 8/28/12, at 3:27  ated the resident was a facility on 5/17/12 and 5/21/12. Diagnoses atory insufficiency, betes mellitus type 2, ension, and PEG Endoscopic	F032	TAG	F322 NG Treatment/Se Restore Eating Skills  1. Residents affected to alleged deficient practice;  One resident (#149) was for to have been affected by the alleged deficiency.  2 All residents with gast tubes are at risk to be affer the alleged deficient practice;  An audit of all resident's with gast rostomy tubes was conducted 9/17/12 to ensure aphysician orders include gastr residual check frequency with intervention, and placement verification frequency.  3. Systems to ensure deficient practice does not reconcilional check for the control of the contro	rvices- by the und rostomy cted by th all ic alleged cur; I will	DATE 09/21/2012
	(Percutaneous Gastrostomy) t	Endoscopic ube placement. The indicated the resident				/12. ator sed n	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	A. BUILDING		COMPL	COMPLETED	
		155694	B. WIN			08/31/	2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER	1		116 BE				
RET7 NII	IRSING HOME				RN, IN 46706			
DE 12 NO	TONE			AUDUN				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	Further review	of the closed record, at			and Enteral Therapy Physiciar	1		
	11:09 a.m., on	8/29/12, indicated the			Orders.			
	resident was d	ischarged to the			·Monday- Friday daily an aud			
	hospital on 5/2	•			of all residents with gastroston tubes will be completed to ens			
	respirations ha				gastric residual check frequen			
	Toopii ationo na	a doddda.			with intervention and placemen			
	Boylow of a Li	oton, and Dhysias			verification frequency are	-		
		story and Physical,			completed and documented. D	NS		
		rom the hospital,			will review audits and provide			
		esident was admitted to			further education and/or			
	the hospital on	4/6/12 due to			disciplinary action as needed.			
	Ventilator-depe	endent respiratory			4. Monitoring to ensure	•		
	failure, status p	oost tracheostomy,			deficient practice does not rec	ur;		
		tus post percutaneous			·DNS and/or designee will			
	endoscopic ga	· · · · ·			complete the Enteral Therapy CQI to physician orders includ	Δ		
		is, and right upper			gastric residual check frequen			
	•				with intervention, and placeme	•		
	extremity deep	vein thrombosis.			verification frequency. CQI for			
	Dovious of the	racidant program			will be completed weekly x 4,			
		resident progress			monthly x 3, and then quarterly			
	nursing notes i	ndicated the following:			thereafter to monitor. Findings			
					be brought to the CQI committ	ee		
	5/20/12 8:58 p.	.m. Resident was alert			monthly then quarterly with	d		
	and oriented tir	mes 3 and cooperative,			tracking and trending discusse If CQI reveals below the 90%	u.		
	and able to foll	ow simple tasks and			threshold an action plan will be	<b>2</b>		
		ons appropriately.			implemented.	•		
		ube (G-tube) dressing			5. Date of Completion: 09/21/1	2		
		tact and no redness			· ·			
	,							
		g through G-Tube was						
	•	s than 300 cubic						
	-	c) of gastric content						
	was noted.							
	5/21/12 at 12:41 a.m. The weekly							
	nursing note indicated the resident							
	usually slept throughout the night							
		y, and awakened						
		oal and tactile stimuli.						
	Cashy Willi Vell	วลา สาเน เสษเทษ อเทศเนท.						

	OF CORRECTION  IDENTIFICATION NUMBER:  155694	(X2) MULTIPLE CC  A. BUILDING  B. WING	00		TE SURVEY  SPLETED  S1/2012			
	PROVIDER OR SUPPLIER  JRSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE  116 BETZ RD  AUBURN, IN 46706						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE			
	The note indicated oxygen was given at 2 liters per minute via nasal cannula, respirations were even and unlabored, no distress or shortness of breath, abdomen was soft and nontender, and Glucerna was infusing through the G-tube. The nursing note further indicated the resident was complaining of stomach upset and nausea, and a medication was given through the G-tube for this.  5/21/12 at 2:15 a.m., indicated the resident was taking his oxygen tubing off numerous times during the shift, but no distress or shortness of breath was noted.  5/21/12 at 6:13 a.m., indicated the resident was noted to have 2 medium emesis of undigested tube feeding, no residual was noted, the abdomen was soft and nontender, bowel sounds present in all quadrants, and the resident stated he was coughing before the emesis. The resident also refused his breathing treatment saying it caused him to cough and get sick from the medication. The note indicated the physician was notified.  5/21/12 12:17 p.m., The resident did not complain of any nausea or vomiting this shift and the G-tube was patent and no residual noted when placement was checked.  5/21/12 12:20 p.m., The G-tube dressing was changed and the area							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155694			A. BUILDING  B. WING			COMPLETED  08/31/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			116 BE			
BETZ NU	IRSING HOME				N, IN 46706		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
1.10		ube was red with a		0			BILLE
		f brown drainage					
	noted.	r brown aramage					
	dated 5/21/12 athe resident's to degrees, pulse minute, respiral minute, blood p 110/78, and the level was 92%.						
	p.m. on 5/21/12 indicated the plant regarding the resident was not breath and tack signs of cyanos taken and the prespirations 20,	documented until 8:05 2 when the note rysician was called resident's condition; the roted to be short of rycardiac and showed riss. Vital signs were roulse was 104, ryblood pressure rygen saturation level					
	was called again 5/21/12, and a 5/21/12 at 8:25 physician called send the resident Emergency room	indicated the physician in at 8:15 p.m. on nursing note dated p.m., indicated the d and left orders to ent to the hospital om. The note also esident's family was					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155694	B. WING		08/31/2012
N41 55 05 5	DROLUBER OF STATE			ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	K	116 BE	TZ RD	
BETZ NU	JRSING HOME		AUBUF	RN, IN 46706	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	A nursing note	, dated 5/21/12 at 8:57			
	p.m., indicated	I the physician was			
	•	and agreed for the EMS			
	_	e resident to the			
	Emergency ro				
		····			
	There was no	further documentation			
		record regarding this			
	incident.	record regarding this			
	incluent.				
	OMA # 6 was	interviewed at 1:47			
	•	12. She indicated she			
		st hall on the evening			
		2, passing medications			
		s. She indicated			
		had a G-tube so the			
	nurse gave the				
		She remembered the			
		ransferred using a			
	hoyer lift and r	emembered she had			
		n the evening of			
	5/21/12 to use	the urinal or bedpan.			
	She indicated	he was able to			
	communicate	his needs. She			
	indicated the r	esident had an emesis			
	and she report	ed this to the RN #5.			
		at approximately 5:00			
		12, LPN #9 who was			
	l •	other hall had come			
		N #5. She indicated			
	•	resident was sick, and			
		he episode of emesis to			
	•	dicated when she			
		t that day she was told			
	lo keep an eye	e on the resident			

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STATEMEN	T OF DEFICIENCIES	OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155694	B. WIN	G		08/31/2	2012
NAME OF B	DROVIDED OD GLIDDI IED		•	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	C.		116 BE	ΓZ RD		
BETZ NU	JRSING HOME			AUBUR	N, IN 46706		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
		as sick. QMA #6					
		vent into the resident's					
		nes that evening					
		sident had turned his					
	. •	ne time for a bedpan					
	and one time b	ecause of the emesis.					
	LPN #8 was in	terviewed, at 2:06 p.m.,					
		d indicated on the					
	· ·	1/12, during shift					
	1	vious shift reported the					
		omited on the night					
		ndicated she went in					
		oom and checked for					
		ne feeding tube and					
		e. She indicated the					
		good day, was up in					
		visitors, went to					
		no vomiting, and did not					
		ything during her day					
	shift.	yamig dainig nor day					
		when she left the					
		p.m., on 5/21/12, the					
	resident was fi						
		··· <del>·</del> ·					
	RN #5 was inte	erviewed, on the					
	telephone, at 2	::42 p.m., on 8/29/12.					
	She indicated	she had worked at the					
	facility approxing	mately one year.					
	She indicated s	she worked the					
	evening shift of	n 5/21/12 and was told					
		sident had vomited on					
	•	indicated that evening					
		transferred the					
		from his chair, they					
	l	· · · · · · · · · · · · · · · · · ·	1				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155694	A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL <b>08/31</b> /	ETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE TZ RD N, IN 46706		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	Ε	(X5) COMPLETION DATE
	was "turning bl She indicated s what time this of called the physic respond right at she called him send the reside indicated she se p.m., on 5/21/1 was fine at that he did refuse he and indicated the had an emesis she could not re- the resident and feeding tube the she did not turn that evening. So called the nurse and that nurse She indicated the her into the resident and the resident and to the room the and his head we She indicated se resident and to then called the indicated the 2 room when she physician. She	she did not remember occurred, but she sician, who did not away. She indicated again and was told to ent to the hospital. She started working at 2:00 2, and the resident time. She indicated is breathing treatment, he was nauseous, and in bed. She indicated emember if she gave ything through the at night, but indicated in the feeding tube off the indicated the CNA is from the other hall turned off the feeding. When the CNAs called sident's room, he was indicated at that time last to elevate his when she had gone he resident was in bed was "a little flat." She assessed the ok his vital signs, and physician. She CNAs were in the					

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Facility ID: 000306

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155694	B. WIN	G		08/31/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
				116 BE			
BETZ NU	JRSING HOME			AUBUR	N, IN 46706		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	still breathing.						
		terviewed, on the					
		:28 p.m. on 8/29/12.					
	She indicated s	she worked the East					
	hall quite often	and had taken care of					
	the resident on	5/20/12 as well as					
	5/21/12. She in	dicated the resident					
	was heavy set,	was a 2 person assist,					
	was younger, h	nad a feeding tube and					
	had to sit up ar	nd not lie down due to					
	this. She indica	ited when she took					
	care of him on	5/20/12, and the					
	resident was fir	ne. She indicated she					
	and another Cl	NA, who no longer					
		acility, worked together					
		I. She indicated at					
	approximately	2:00 p.m., or so, she					
	''	eeing the resident,					
		checking rooms and					
		esident didn't look like					
		well. She indicated he					
	_	ne recliner, and looked					
	_	red." She indicated					
		ner CNA did rounds,					
		e residents, toileting,					
	_	up for dinner. She					
	"	dent #149's call light					
		d 6 p.m., and she					
		r CNA to go into the					
	resident's room	•					
		esident had vomited					
		f "stooped over " in the					
		•					
		cated he seemed fairly					
	alert, and told	the CNAs he didn't feel					

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Event ID: MZ9Q11

Facility ID: 000306

If continuation sheet

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PRINTED: 10/05/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  155694	A. BUII	LDING	00	COMPLETED 08/31/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	25.01/	
NAME OF P	ROVIDER OR SUPPLIER			116 BE			
BETZ NU	IRSING HOME				N, IN 46706		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
TAG		·		IAG			DATE
	_	ted to go to bed as he vould fall out of the					
		indicated they cleaned					
		and put him to bed.					
	•	ne seemed a little					
		nutes or so, and they					
		m with him a large					
		e that night. She					
	indicated after	•					
		She indicated he was					
	_	hat, sometimes a little					
	_	"quite a bit." She					
	· ·	nd 7:30 -8 p.m., he					
		nresponsive." She					
		st time the resident					
	vomited she tol	d RN #5. She					
	indicated the nu	urse came in the room,					
		I the resident to see					
	-	ing. She indicated the					
	resident was try	ying to tell them he					
	was having trou	uble breathing. He					
	would frequentl	ly take off his oxygen					
	tubing, but indic	cated he had also					
	done this prior	to this night.					
	CNA #7 indicat	ed she didn't see any					
	other nurses ot	her then RN#5 in the					
	resident's room	that evening. She					
	indicated RN#5	had hooked up a vital					
	sign monitor in	the room and his					
	oxygen was "re	-					
	indicated she c	ould see the resident's					
	pulse and oxyg	en level on the					
	monitor.						
		the nurse had placed					
	the vital sign m	onitor on him the first					

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Event ID: MZ9Q11

Facility ID: 000306

If continuation sheet Page 29 of 42

PRINTED: 10/05/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII		00	COMPLETED	
		155694	A. BUII B. WIN			08/31/	2012
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
BETZ NU	IRSING HOME			116 BET AUBUR	TZ RD N, IN 46706		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	1	ID	DROUDEDIG N. AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		d. She indicated the					
		een unresponsive even					
		ulance arrived. She					
		esident turned a "bluish					
	arrived, and he	efore the ambulance					
		ling" noise and it					
		s "aspirating on his					
		though we had him					
		e indicated she and the					
	•	e checking him often					
		nurse in quite a few					
		icated the ambulance					
		9 p.m. and before this					
		nt's oxygen level was					
		en 40 and 80, and most					
	_	nced around the mid					
		She indicated the					
		was trying to talk, but					
		n, was making hand					
		ng his head around,					
	and was not ve	rbal. She indicated					
	about 1/2 hour	before the ambulance					
	arrived, they co	ould not get any					
	response out of	f him, and he would					
	just open his ey	es. She indicated she					
	noticed his skin	started turning blue					
	around 7:30 -8:	00 p.m.					
	The Dissets of	Numerica Complete					
		Nursing Services					
	` ,	I #1, the East hall Unit					
	_	interviewed at 10:34					
	•	2. The DNS indicated					
	_	een employed at the					
	lacility since At	igust, 2012 and was					

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Event ID: MZ9Q11

Facility ID: 000306

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	ILTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155694	B. WINC	3		08/31/	2012
NAME OF E	PROVIDER OR SUPPLIE	ED.		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFEIL			116 BE	TZ RD		
BETZ NU	JRSING HOME			AUBUR	N, IN 46706		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		at the time of the					
	•	ever, LPN #1 was					
	employed at t						
		ited she was not in the					
	1	ime of the incident, but					
	•	one call from RN #5 and					
		vening shift supervisor.					
		she was not available					
	_	t called, but then called					
		d was told about the					
		dition. She indicated by					
		eturned their call, the					
		already been taken to					
	the hospital.						
		LPN #1 were informed					
		concerns about the					
		n and assessment, and					
		would investigate to					
	see if they cou						
	documentation	n.					
	The Discrete	of Normalina Compilers					
		of Nursing Services					
	, ,	erviewed, at 2:40 p.m.,					
	· · · · · · · · · · · · · · · · · · ·	nd indicated she could					
	1	urther documentation in					
		cord. She indicated she					
	-	N #9 who indicated she					
	•	N#5 on 5/21/12, and					
		the feeding tube					
		DNS indicated the					
		se had reviewed the					
		on 8/29/12, and was not					
	able to find an						
	documentation	n.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155694				ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPI	ETED
		155694	B. WIN			08/31	/2012
NAME OF F	ROVIDER OR SUPPLIEF	t			DDRESS, CITY, STATE, ZIP CODE		
BETZ NU	JRSING HOME		116 BETZ RD AUBURN, IN 46706				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	3 RIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		terviewed, at 2:48 p.m.,					
		th the DNS present.					
		she had worked on					
	Central hall on	_					
		ne CNAs had come					
		sometime on the					
	_	1/12, and asked her to					
	come to East H						
		. She indicated she					
	, ,	ame to her because					
		d on East Hall for a					
	_	they knew her. She					
		n, he was in bed, and					
		well. She indicated his					
	_	pale. She indicated					
		e was running and she					
	_	the CNAs had told her					
		d been vomiting. She					
		5 was not in the					
		n when she went in, but					
		e room, she went and					
		t she needed to call the					
		send the resident out to					
	• •	ne indicated she had					
		resident before this,					
	but his breathir	ng was not good. She					
	indicated she t	ook his oxygen level					
	and didn't reme	ember what it was, but					
	indicated it was	s not good. She					
	indicated she o	lid not observe					
		he resident was just					
		She indicated she					
		er if he had his eyes					
	opened, but he	was not responsive.					

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Event ID: MZ9Q11

Facility ID: 000306

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155694	B. WIN			08/31/	2012
			D. ((1)		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹		116 BE	TZ RD		
BETZ NU	IRSING HOME				N, IN 46706		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		she listened to his					
		cated, "I thought he					
	had probably a	spirated."					
	The DNS was	interviewed at 9:29					
	a.m., on 8/31/12, and indicated the						
	only inservice	completed related to					
	the incident on	Resident #149 was					
	regarding callir	ng 911 if the physician					
	could not be re	eached.					
	Review of the i	inservice, dated					
	5/24/12, and p	rovided by the DNS, at					
	this time, indica	ated, "send full code					
		for resp (respiratory)					
	failure" and "ge						
	_	oon admission to					
	facility. "						
	idolity.						
	RN #11 was in	terviewed, with the					
	DNS present, a	at 9:45 a.m., on					
	8/31/12. She ir	ndicated she had					
	worked the eve	ening of 5/21/12, and					
		anager on Central hall.					
		LPN #9 had told her					
		s sending one of the					
		e hospital. RN #11					
		only went to the					
		n for approximately 5					
		o the ambulance					
	•	id not assist with the					
		nly helped with the					
		my neiped with the					
	paper work.						
	Deview of an E	Emergency Medical					
		Emergency Medical					
	Services (EMS	s) prehospital patient					

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Event ID: MZ9Q11

Facility ID: 000306

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00	(X3) DATE SURVEY  COMPLETED
7 II.D I LAIN	155694	A. BUILDING		08/31/2012
		B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER	116 BE		
BETZ NU	JRSING HOME	AUBUR		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE COM EETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	care report, dated 5/21/12, indicated			
	they had responded to a 911 call regarding a resident with difficulty			
	breathing. When they arrived at the			
	resident's room, the resident was			
	lying in a supine position in bed in a			
	dark room. The resident had oxygen			
	at 2 liters per minute via nasal			
	cannula, and "has a feeding tube			
	running. " The report indicated,			
	"there was a lot of vomit in the			
	patient's bed and all over the floor			
	next to the bed and soiled hospital			
	gown and linens on the chair next to			
	the patient.			
	Nursing staff reports that the patient			
	had began to vomit at about 1800 this			
	evening and that they believe that he had aspirated at that time. Nursing			
	staff reports that at that point the (sic)			
	moved the patient to the bed.			
	Patients skin was purple and with			
	respirations at 4 per minute. Patient			
	still vomiting large amounts from nose			
	and mouth."			
	The resident was taken by cot and			
	bagged using oxygen. The resident			
	was suctioned "many times while in			
	the ambulance" and when placed on			
	the monitor showed asystole , no			
	pulse, no respirations, and the pupils			
	were dilated and non reactive. CPR			
	was started without improvement or			
	change.			

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Event ID: MZ9Q11

Facility ID: 000306

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETED	
		155694	B. WING	J		08/31/2012	
NAME OF P	ROVIDER OR SUPPLIER	<b>t</b>			ADDRESS, CITY, STATE, ZIP CODE		
5577.11	100110 110145			116 BE			
BEIZNU	JRSING HOME			AUBUR	N, IN 46706		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DIA TOLLANCI )	DATE	—
		policy for change in					
	•	ided by the DNS, at					
	9:45 a.m., on 8/31/12, indicated the following:						
	_	of this facility that all					
		ident condition will be					
	_	to the physician and					
		ible party, and that					
		nely, and effective					
	intervention oc	•					
		for life threatening					
		ed the licensed nurse					
	_	ppropriate first aid					
		emergency response					
		red on the scene, the					
		would inform the					
	attending phys	ician, alternate					
	physician, or M	ledical Director of					
	resident status	as soon as possible					
	before, during,	or after the change of					
	condition occur	rred or when the					
	resident crisis l	had been managed,					
	and document	the notification.					
		ng actions, physician					
	· ·	esident assessment					
		uld be documented in					
		cord, and the nursing					
	supervisor wou						
	•	life threatening					
	changes of cor						
	The "Acute Me	•					
	•	cated the following:					
	•	or serious change in a					
		lition manifested by a					
	marked change	e in physical or mental					

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Event ID: MZ9Q11

Facility ID: 000306

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155694		(X2) MUL A. BUILD B. WING		nstruction 00	(X3) DATE ( COMPL 08/31/	ETED	
	PROVIDER OR SUPPLIE	R		116 BET	DDRESS, CITY, STATE, ZIP CODE IZ RD N, IN 46706		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	the physician of physician visit care evaluation. If unable to of physician or all timely manner Director for measurement and be documented as soon resident needs. Review of the Therapy, proving 11:50 a.m., on was the policy the physician or will take, note, physician orders and orders should be documented and be documented and be documented and be documented and be documented as a soon and be documented and be documented and be documented as a soon and be documented and be documented and be documented as a soon as a soon and be documented as a soon and be documented as a soon as a soo	contact the attending ternate physician in a notify the Medical edical intervention. ctions/interventions mented in the medical as possible after shave been met.  facility policy for Enteral ded by the DNS, at 8/31/12, indicated It of the facility to ensure splan of care was at licensed nurses physician's plan of istant manner. Icated a licensed nurse and implement ers for enteral therapy, buld be obtained as all check frequency with and placement					

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Event ID: MZ9Q11

Facility ID: 000306

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE S  A. BUILDING (00)  ON/31/			ETED		
		155694	B. WING	·		08/31/	2012
NAME OF PROVIDER OR SUPPLIER BETZ NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE  116 BETZ RD  AUBURN, IN 46706					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0323 SS=E	The facility must environment ren hazards as is por receives adequal assistance device. Based on obsithe facility failurant ambulatory rememory care while houseked floors in the difference of the "Memorial indicated the frand was wet. staff, who was stated "be care."  During observed 9:31 a.m., the seated at table residents were were in wheel staff left the autother facility serial resident was cout of the room knock down the receivers and the room knock down the receivers and the resident was cout of the room knock down the receivers and the rec	ensure that the resident nains as free of accident ssible; and each resident at supervision and ses to prevent accidents. ervation and interview, and to ensure 13 of 25 sidents residing in the unit were kept safe seping staff mopped the ning room.	F032	23	F323 Free of Accident Hazards/Supervision/Devices? Residents affected by the alleg deficient practice;     Thirteen of 25 ambulatory residents were found to have been affected by the alleged deficiency. Residents being monitored to prevent entering wet floor area. 2 All residents residing on the cotta are at risk to be affected by the alleged deficient practice;     A waist high "guideline" safe strap that attaches to each sid the dining room entrances will utilized with a wet floor sign will floors are wet to prevent reside from entering the wet floor are. The design of th strap has a spring mechanism on one end alleviate fall risk. It was assess for safety by DNS. Nursing/Housekeepir dministrative Staff will also be responsible to monitor resident when floor is wet and "guideling is engaged to assure they do renter the wet floor area.  3. Systems to ensure alleged deficient practice does not reconversely that the inserviced on ensuring that the inserviced in ensuring that the inserviced on ensuring that the inserviced in ensuring	ged  ged  ged  ged  ged  ged  ged  ged	09/21/2012

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Event ID: MZ9Q11

Facility ID: 000306

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATIO		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPL	ETED	
155694		B. WIN		-	08/31/	2012	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER			116 BETZ RD				
BETZ NURSING HOME				N, IN 46706			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	On 8/29/12 at 9 housekeeping "Memory Care' proceeded to not observation, or the dining room housekeeping table, sat her docontinued to make the dining a table. At 9:42 a.m. ar into the dining a table. At 9:44 resident walked the wet floor ar The housekeep wet floor signs dining room.  Interview with the supervisor on 8 indicated staff dining room after indicated it is her from wandering	9:30 a.m. staff came to the ' dining room and nop the floor. During ne resident walked into n and the staff walked her to a own and then			"guideline" strap and the wet fl sign are in place when floors a wet and preventing residents f walking on the wet floor by the DNS and/or designee by 9/21/. Staff Development Coordina will educate newly hired licens personnel and housekeeping personnel during orientation or ensuring that the "guideline" st and the wet floor sign are in pl when floors are wet and preventing residents from walk on the wet floor.  A daily audit will be conduct on one meal service per day rotating meals to assure the "guideline" strap and the wet fl sign are in place when floors a wet and Nursing/Housekeeping/Adminiative Staff will monitor that residents are not entering the floor area.  Monitoring to ensure alleged deficient practice does not recubns and/or designee will complete the Environmental Safety/Nursing CQI to ensure resident safety when floors are wet. CQI form will be complete weekly x 4, monthly x 3, and the quarterly thereafter to monitor. Findings will be brought to the CQI committee monthly then quarterly with tracking and trending discussed. If CQI reveloe below the 90% threshold an action plan will be implemente 5. Date of Completion: 09/21/10	are rom 12. ator ed n trap ace sing ed door are str wet d ur;	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
		155694	B. WIN		<del></del>	08/31/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
BETZ NURSING HOME			116 BETZ RD AUBURN, IN 46706				
BETZ NORGING HOWE			AODON				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
F0441	483.65						
SS=E		ITROL, PREVENT					
	SPREAD, LINEN						
	•	establish and maintain an					
		Program designed to					
		anitary and comfortable					
		to help prevent the					
	•	transmission of disease					
	and infection.						
	(a) Infection Cont	rol Program					
	· ·	establish an Infection					
	Control Program						
		controls, and prevents					
	infections in the fa	•					
		procedures, such as					
	· ·	be applied to an individual					
	resident; and	• •					
	(3) Maintains a re	ecord of incidents and					
	corrective actions	related to infections.					
	(b) Preventing Sp						
	· ·	ection Control Program					
		resident needs isolation to					
		nd of infection, the facility					
	must isolate the r						
	• •	ust prohibit employees with					
		disease or infected skin					
		ct contact with residents or					
	•	t contact will transmit the					
	disease.	ust require staff to wash					
	• •	each direct resident contact					
		ashing is indicated by					
	accepted profess						
	accepted protoco	practice.					
	(c) Linens						
	` '	nandle, store, process and					
		o as to prevent the spread					
	of infection.						
	Based observa	ition, record review,	F04	41	F441 Infection Control, Preven	t	09/21/2012
		the facility failed to			Spread, Linens1. Residents		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	a. Building 00		00	COMPLETED	)
155694		155694	B. WING			08/31/201	2
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
BETZ NURSING HOME			116 BETZ RD AUBURN, IN 46706				
					,		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	60	(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	re CO.	MPLETION DATE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG		at l	DATE
	ensure nursing staff washed hands				affected by the alleged deficie practice;	"	
	_	nedication passes,			·Three residents (#147, #10,		
		3 of 15 residents		and #112) were found to have			
	observed (#14	7, #10, and #112).			been affected by the alleged		
					deficiency. Staff are using appropriate infection control		
	Findings include	de:					
					measures when passing		
	On 8/29/12 fro	m 3:30 P.M. until 4:20			medications to these residents 2 All residents receiving	·.	
	P.M., Nurse #1	12 was continuously			medications and eye drops are	e at	
	observed while				risk to be affected by the alleg		
		residents on the 500			deficient practice;		
	Hall on the Central Unit.				Residents will be assessed	as	
					needed for any s/s of possible		
	At 3:30 P.M., N	Juraa #12 waa			infection and the physician		
	· ·				notified as needed.		
	•	repare oral medications			·Licensed personnel will ass hand hygiene is completed	ure	
		ion cart for Resident			between residents, when hand	ls	
		e was observed to use			become contaminated and price		
	_	and sanitizer to clean			to donning and removing glove		
	her hands. The	e nurse was observed			3. Systems to ensure alleged		
	to take the me	dications into the			deficient practice does not rec		
	resident's roon	n, administer the			·Licensed nursing personnel		
	medications, a	nd return to the			be in-serviced that hand hygie is completed between residen		
	medication car	t. The nurse was not			when hands become	.5,	
	observed to us	se hand sanitizer or to			contaminated and prior to		
	wash her hand	ls after administering			donning and removing gloves	by	
		s. The nurse was			the DNS and/or designee by		
		to prepare eye drop			9/21/12.		
		r Resident #147. The			·Staff Development Coordina will educate newly hired licens		
					personnel during orientation th		
	nurse was observed to enter the resident's room and put on exam gloves. The nurse was not observed to wash her hands prior to putting on the gloves. The nurse was observed to administer the eye drops to the resident and then remove the gloves				hand hygiene being completed		
					between residents, when hand		
					become contaminated and price		
					to donning and removing glove		
					·Three times weekly an audi		
					licensed nursing personnel wil	i be	
					completed to ensure hand		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED		
155694		A. BUILDING		08/31/2012		
1		B. WING	ADDRESS, CITY, STATE, ZIP CODE	33.3 23 12		
NAME OF PROVIDER OR SUPPLIER		116 BE				
BETZ NURSING HOME		AUBURN, IN 46706				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	and return to the medication cart in the hallway. The nurse was not observed to wash her hands or to use hand sanitizer after removing the gloves. The nurse was then observed to prepare oral medications for Resident #10. The nurse was observed to enter the resident's room, obtain his blood pressure, and then administer the medications to the resident. The nurse was not observed to wash her hands or to use hand sanitizer prior to administering the medications. The nurse was then observed to return to the medication cart to prepare oral medications for another resident. Prior to preparing the medications, the nurse was observed to use a gel based hand sanitizer. The nurse was observed to enter the resident's room and administer the medication. The nurse was not observed to use hand sanitizer or to wash her hands after administering the medications. The nurse then returned to the medication cart and prepared oral medications for Resident #112. The nurse was observed to enter the resident's room and administer the medications. The nurse was not observed to wash her hands or to use hand sanitizer prior to administering the medications. After administering the medications, the nurse was observed to wash her		hygiene is being completed between residents, when hand become contaminated and pri to donning and removing glov Audit will encompass different nurses on all three shifts.  4. Monitoring to ensure allege deficient practice does not recomplete the Infection Control CQI to ensure appropriate has hygiene. CQI form will be completed weekly x 4, monthl 3, and then quarterly thereafted monitor. Findings will be broug to the CQI committee monthly then quarterly with tracking ar trending discussed. If CQI revibelow the 90% threshold an action plan will be implemented. Date of Completion: 09/21/1/19/19/19/19/19/19/19/19/19/19/19/19/	or es. d cur; ind y x er to ght eals		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155694		(X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING  (X3) DATE SURVEY  COMPLETED  08/31/2012				
NAME OF PROVIDER OR SUPPLIER BETZ NURSING HOME		116 BE		CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	hands with soap and water.  The facility's Director of Nursing Services Specialist (DNSS) was interviewed on 8/31/2012 at 8:50 A.M. During the interview, the DNSS indicated nursing staff was to use hand sanitizer before and after administering medication to each resident. The DNSS indicated nursing staff was to wash hands with soap and water after every third resident or if hands become soiled or contaminated. The DNSS further indicated nursing staff was to wash hands with soap and water before and after using exam gloves.  A nursing skills validation checksheet, entitled "Medication Pass Procedure", dated 7/2011, was provided by the DNSS on 8/31/2012 at 9:50 A.M. The DNSS indicated the checksheet also served as the facility's hand washing policy. The checksheet indicated "Hand hygiene MUST be performed between residents."  3.1-18(I)					

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